Survey: Psychological Impact of COVID-19 in Patients With Allergic Diseases

1. Gender
   • Female
   •Male
   •Other
2. Age in years: (#)
3. Place of residence (City, State, Country)

4. Who do you currently live with? (In the last two weeks)
   • I live alone
   • I live with relatives
   • I live with my couple
   • I live with friends
   • Other
5. Type of home you currently live in:
   • Apartment without balcony
   • Apartment with balcony or terrace
   • House with a backyard
   • House without a backyard
   •Cottage
6. Education Level: •Elementary •Middle School • High school •Bachelor's degree •Postgraduate •Other
7. Marital status: • Single •Married •Divorced •Widow
8. Do you have any of the following allergic diseases? (more than one option can be answered)
   •Allergic rhinitis
   • Asthma
   •Atopic dermatitis
   • Urticaria (hives)
   • Food allergy
   • Drug allergy
   •None
9. Are you currently undergoing treatment to control your allergic diseases?
   • Yes
   •No
   •Does not apply
10. Do you suffer from any of the following chronic diseases? (more than one option can be answered)
    •Hypertension
    •Diabetes
    • High cholesterol
    •Heart diseases
    •Thyroid diseases
    • Rheumatologic diseases
    • Cancer
    •Reflux

11. Are you currently undergoing treatment to control your chronic diseases?
    • Yes
    •No
    •Does not apply
12. Current situation in the COVID-19 pandemic (more than one option can be answered):
    • I am in quarantine
    • I am not in quarantine
    • I work away from home
    • I work at home (home office)
    • I am healthcare provider personnel
    • I am security personnel
13. Have you been in contact with people diagnosed with / or suspected of having COVID-19?
    • Yes
    •No
14. Have any of your family members been diagnosed with COVID-19?
    • Yes
    •No
15. Have you been diagnosed with COVID-19?
    •Yes
    •No
16. Are you worried about the economic situation that could result from the COVID- 19 Pandemic?
    • Yes
    •No
17. Have you had any changes in your work situation due to COVID-19? (more than one option can be answered)
    • I continue working the same
    • I am working from home
    • My salary was reduced.
    • My schedule has been reduced.
    • Other
18. Have you had any difficulties paying the following expenses? (more than one option can be answered)
    • Rental payments (house, apartment, office, business)
    • Payment of loans and bank mortgages
    • Payment of basic utilities (electricity, water, gas, etc.)
    • Purchase of food for the home
    • Medicines and health services
    • I have not had difficulty

    *** Below is a list of situations that people can experience during the COVID-19 pandemic. Read each question and indicate how difficult it has been for you in the last 2 weeks.**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it.	0	1	2	3	4
2. I had trouble staying asleep.	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry.	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6. I thought about it when I didn´t mean to.	0	1	2	3	4
7. I felt as if it hadn´t happened or wasn´t real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn´t deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed or hopeless?	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your familiy down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?	0	1	2	3